DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from April 14, 2008 through April 17, 2008. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a population of eight males with variouslevels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and one day program, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	W 000	2008 MAY 29 A 8:40 RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that all personnal making entries into the clients' records were signed, for one of the four clients in the sample. (Client #3) The finding includes: Review of Client #3's medical record on April 17, 2008 at 2:00 PM revealed a nursing quarterly assessment dated March 2008. The assessment was completed, but not signed by the person completing it.	W 114	W114 This Standard will be met as evidenced by: 1. Client #3 Quarterly assessment is currently signed and dated. Director of Nursing will provide additional training on standard practices when making entries on medical records	5.22.08 ongoing
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Bland — TITLE: DNS — (X6) DATE: 5/8/08

For deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 1 and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for two of the four clients in the sample. (Clients #2 and #4) The findings include: 1. During the entrance conference on April 14, 2008 at 8:50 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #2 received psychotropic medications for behavioral management. Review of the client's current physician orders revealed that the client received Prozac 40 mg, once a day. Further record verification indicated that the medication was incorporated into the client Behavior Support Plan (BSP) dated February 28, 2008 to address targeted behaviors that included verbal aggression, physical aggression, self-injurious behaviors and property destruction. Interview with the QMRP on April 15, 2008 at approximately 9:30 AM revealed that Client #2's sister is very involved in his life but are not the client's legal guardians. Review of the client's, psychological assessment on June 5, 2007 at approximately 1:21 PM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #2's sister of the health	W 124	W124 This Standard will be met as evidenced by: 1. Client #2 sister & client #4's mother are actively involved in their service plan and they are the decision maker for their family member. They had in the past signed off on consent for psychotropic medication and behavior support plan. However, the document has been purged from the record. QMRP will follow up with client #2 and client #4 family members to review and sign off on current psychotropic medication and behavior support plan. QMRP will review and discuss potential risk and benefit with both family member. QMRP will ensure that family member is fully knowledgeable and understand the rights of the clients. QMRP will provides documentation of information regarding all efforts to involve family members in the decision making process as well as on-going measures to ensure protection of the client's right. In addition, QMRP will ensure that this information is filed inside the client record with a "do not thin "marked clearly on the document to prevent future removal of the information from client's record.	5.8.08 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID1	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 2 benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. 2. Client #4 was observed during the evening medication pass on April 14, 2007 at approximately 5:00 PM and was administered Revia 25 mg and Seroquel 300 mg. Review of the client current physician's orders revealed that the client was prescribed the aforementioned medication twice a day. Interview with the medication nurse at approximately 5:20 PM revealed that Client #4 was prescribed these medications for behavioral management. Further interview with the LPN revealed that the medications were incorporated into Client #2's BSP dated March 30, 2007 to address targeted behaviors that included disrobing and masturbation, screaming/crying, physical aggression, property destruction, and self-injurious behaviors. Interview with the QMRP on April 15, 2008 at 9:30 AM revealed that Client #2's mother was involved in his life but was not the client's legal guardians. Review of the Client #4's, psychological assessment dated July 5, 2007, at approximately 1:21 PM revealed that the client did not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #4's mother of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP.	W 124		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159	W159 This Standard will be met as evidenced by: 1. Client #1 Occupational therapy assessment is now completed and filed in his record. QMRP will review individual need prior to the time of the ISP and ensure that all recommended assessments are completed and file on client record.	5.1.08 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 3 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the Qualified Mental Retardation Professional (QMRP) failed to coordinator services for one of the four clients in the sample. (Client #1) The findings include: 1. The QMRP failed to ensure that Client #1 received an Occupational Therapy assessment as ordered. On April 14, 2008 at 7:45 AM, Client #1 was observed with crooked fingers. Review of Client #1's medical record on April 15, 2008 revealed a nursing note dated March 13, 2008 that indicated that the client's finger was contracted more that usual. The Primary Care Physician was notified and requested an Occupational Therapy consult. Interview with the QMRP and Assistant Program Director indicated the assessment had not been completed because the facility was seeking a new Occupational Therapy consultant. 2. The QMRP failed to ensure program objectives was implemented as indicated in the IPP. [See W249] 3. The QMRP failed to collect data in accordance with clients' training program plan. [See W252] 4. The QMRP failed to ensure that each client's	W 159	2. Reference W249 3. Reference W252 4. Reference W124	5.1.08 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 4 behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent. [SeeW124, and W263]	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include: 1. The facility failed to document the implementation of programs in accordance with Individual Program Plan (IPP) for one of the four clients in the sample. [See W262] 2. The facility failed to ensure that Clients received all prescribed medications without error for three of the four clients in the facility. [See W369]	W 189	W189 This Standard will be met as evidenced by: 1. Reference W 262 2. Reference W369	5.9.08 ongoing
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the	W 249		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	090192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 5 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to provide continuous active treatment for two of the four clients included in the sample. (Clients #1 and #4) The findings include: 1. The facility failed to implement Client #1's activities of daily living program as evidenced below: Review of Client #1's Individual Support Plan (ISP) dated June 6, 2007, on April 15, 2008, at 12:30 PM revealed a goal to improve his activities of daily living skills. The objective stated "Given hand over hand assistance, [the client] will brush his hair on 80% of the trials recorded for six consecutive months." Review of the QMRP's quarterly reviews reflected no program status. Review of the data sheets reflected that the program was not implemented until March 2008 (nine months later). In an interview with the QMRP on April 15, 2008, he acknowledged that the program did not start until March 2008. 2. The facility failed to implement Client#4's Physical Therapy goal as evidenced by the following: On April 14, 2008 at 4:20 PM, the staff	W 249	W249 This Standard will be met as evidenced by: 1. QMRP in-service on active treatment and the importance of implementation of all program goals/objectives immediately after the interdisciplinary team meeting. In addition, management will continue to complete periodic audit of the individual files to ensure compliance with this training as set forth. 2. Physical Therapy has completed training on various repositioning positions as recommended for client #4 and all other individuals that reside in the home. QMRP will continue to monitor staff completion of the repositioning activity to ensure the program is completed as outlined. 3. Social Worker has completed in-service training on client #1's social program to further train the staff on the correct implementation of program as outlined. QMRP and home manager will continue to monitor program weekly and sign off on each individual program book to ensure that all efforts are carried out as outlined.	5.15.08 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 6 repositioned Client #4 out of his wheelchair onto a mat. The staff placed the client on his back and instructed him to stretch his legs out. The staff positioned the client back into his wheelchair at 4:30 PM. Review of the client's Individual Program Plan (IPP) on April 15, 2008 at approximately 11:50 AM, revealed that the client had an objective to "tolerate prone position for 10 minutes." During the exit conference on April 17, 2008, it was brought to the attention of the QMRP that the client was repositioned in the supine position instead of the prone position as indicated in the clients IPP. 3. On April 14, 2008, at 11:08 AM, Client #3 was observed with a radio with ear-pieces in his ears. According to the staff, the client really likes music and is usually seen with his radio earpieces attached to his ears. Review of Client #3's program objectives on the same day, revealed an objective for the client to "select a musid related activity to attend in the community with verbal assistance for six consecutive months by 6/08." According to the interventions/methods documented on the program, the staff were to present two (2) choices to the client. When asked about the community activities Client #3 participated in, the staff indicated that the client attended the Chateau. Review of the skill acquisition/data collection sheets for the aforementioned program objective revealed the following: November 2007, the client was not presented with a selection of activities; January 2008, the client was not presented with a selection of activities;	W 249	W249, continued... 4. Physical therapist has provided additional training to staff both at the home and the day program to ensure client #1 walking program is carried out correctly and to further outline the use of wheelchair as recommended by the therapist. QMRP will continue periodic monitoring of the program to ensure staff compliance with recommendation as outline on the program. 5. QMRP will train staff both at home and at the day program on head rubbing protocol for client #1. QMRP will create a brief outline of the protocol to be place in client #1 record to ensure that all staff is aware and follow protocol as specified.	5.15.08 Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 7 February 2008, the client was not presented with a selection of activities; April 2008, the client was not presented with a selection of activities. He was offered cards as a choice. In an interview with the QMRP on April 15, 2008 at approximately 1:30 PM, he acknowledged that the staff were not implementing or documenting the program as outlined in the IPP. 4. The facility failed to encourage Client #1 to participate in his walking program as opportunities arose. On April 14, 2008 at 8:02 AM, staff was observed propelling Client #1 in his wheelchair to his bedroom. At 8:40 AM, staff was observed propelling the client in his wheelchair to the van for day program. At 3:20 PM, staff was observed propelling the client in his wheelchair from the van, upon arrival from the day program. At 4:00 PM, staff was again observed propelling Client #1 in his wheelchair to his bedroom to be changed. At 6:18 PM, Client #1 was observed walking down the hall with staff assistance. Interview with the QMRP on April 15, 2008 at approximately 11:00 AM indicated that the Client #1 had a walking program developed by the Physical Therapist. Review of the clients IPP dated June 6, 2007 at 2:30 PM, revealed a program objective which stated, "Given stand by assistance, [the client] will ambulate for 10 minutes for three days per week for 12 consecutive months". Further review of the Physical Therapy assessment dated May 2007, revealed a recommendations that the client	W 249		

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 8 should use a wheelchair for long community outings, only. 5. Interview with the Day Program Coordinator on April 14, 2008 at approximately 10:30 AM indicated that Client #1 likes staff to rub his head. However the staff have been instructed to shake the client's hand. On April 14, 2008 at 3:55 PM, Client #1 was observed rubbing his head on a direct care staff's chest and arm. Staff #1 shook his hand and then prompted the client to rub his own head. Interview with the Staff #1 indicated that the client likes to have his head rubbed. However there is a protocol in place for staff to implement when the resident request a "head rub". At 6:52 PM, Staff #2 was observed rubbing Client #1's head for three minutes. The client smiled broadly. Review of the Client #1's protocol developed by the Social Worker revealed the following steps: - When staff greet Client #1, the staff should give him a firm hand shake; - When Client #1 attempts to get staff to rub his head, staff should refuse and continue to shake his hand and say, "[the client] it's nice to shake hands". - After shaking hands, without rubbing [the client's] head, staff should again say, [the client] it's nice to shake hands. There was no evidence that the facility implemented the protocol as written.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria	W 252	W252 This Standard will be met as evidenced by: Reference W249	5.15.08 ongoing

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G152	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 9 specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to collect data in accordance with clients' training program plan, for two of the four clients in the sample. (Client #3 and #4) The findings include: 1. On April 14, 2008, at 11:08 AM, Client #3 was observed with a radio with ear-pieces in his ears. According to the staff, the client really likes music and is usually seen with his radio earpieces attached to his ears. Review of Client #3's program objectives on the same day, revealed an objective for the client to "select a music related activity to attend in the community with verbal assistance for six consecutive months by 6/08." According to the interventions/methods documented on the program, the staff were to present two (2) choices to the client. When asked about the community activities Client #3 participated in, the staff indicated that the client attended the Chateau. Review of the skill acquisition/data collection sheets for the aforementioned program objective revealed the following: November 2007, the client was not presented with a selection of activities; January 2008, the client was not presented with a selection of activities;	W 252		

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 10 February 2008, the client was not presented with a selection of activities; April 2008, the client was not presented with a selection of activities. He was offered cards as a choice. In an interview with the Qualified Mental Retardation Professional (QMRP) on April 15, 2008 at approximately 1:30 PM, he acknowledged that the staff were not implementing or documenting the program as outlined in the Individual Program Plan (IPP). 2. Review of Client #3's IPP on April 14, 2008 at 11:30 AM revealed a program objective that indicated that the client would respond yes or no to queries with 80% accuracy when given an actual object or picture. Interview with the QMRP on April 15, 2008 at approximately 1:30 PM, indicated that the client is to answer yes or no to when asked about the object. Review of the program data for January 2009 revealed that on 17/31 trials the staff documented physical assistance. When asked how you provide physical assistance to a yes/no response, the QMRP acknowledged that the staff were not documenting the program as outlined in the IPP nor was the data measurable. 3. Review of Client #4's IPP on April 15, 2008 at approximately 9:50 AM revealed that the client had an objective to "select a music related activity to attend in the community with verbal assistance for six consecutive months by 6/08." According to the interventions/methods documented on the program, the staff are to present two (2) choices to the client. When asked about the community activities Client #3 participated in, the staff	W 252		

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 11 indicated that the client attended the Chateau. Review of the skill acquisition/data collection sheets for the aforementioned program/objective revealed the following: In September 2007 the client was only given the choice of church, no other alternative was given, in January 2008 and February 2008, the choice was movies no other options. In an interview with the Qualified Mental Retardation Professional (QMRP) on April 15, 2008 at approximately 1:30 PM, he acknowledged that the staff were not documenting the program as outlined in the Individual Program Plan (IPP) nor was the data measurable.	W 252		
W 263	483.440(f)(3)(II) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique) including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for two of the four clients in the sample. (Clients #2 and #4) The finding includes: The facility failed to obtain informed consent prior to the use of restrictive measures as described in Client #2 and #4's Behavior Support Plan. [See	W 263	W263 This Standard will be met as evidenced by: Reference W124	5.8.08 ongoing

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 12 W124]	W 263		
W 331	489.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nurses failed to assess clients as required, administer medications without error and ensure the security of the medications. The findings include: 1. The facility's nurses failed to ensure that a health status was reviewed by the nursing staff on a quarterly or more frequent basis. [See W336] 2. The facility's nurses failed to ensure that medication nurse administered prescribed medication without error. During the medication administration observation on April 14, 2008 at 5:30 PM, the medication nurse was observed preparing Client #6's medications. The nurse put the medication in a souffle medication cup to crush the pills and while crushing the medication, three fourths of one pill (Dilantin 50 mg) fell to the floor. The medication nurse continued to crush the remaining pills. NOTE: At 7:35 PM, the medication nurse was informed that the Dilantin pill fell to the floor, at that time she administered another Dilantin pill. The medication nurse was observed throwing the Dilantin pill in the trash can.	W 331	W331 This Standard will be met as evidenced by: 1. Reference W114 2.Additional training will be provided by the RN/D.O.N to all nurses (a)Medication administration(b)Medication disposal Guidelines (c) Medication error policies/ procedures, Medication storage protocol and Standard infection control practices and procedures. R.N will continue to provide a period monitoring of nurses when administering medication to ensure Compliance with the protocol/guidelines as trained. 3. Reference #2	5.22.08 ongoing

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 13 There was no evidence that the facility nurse had notified the primary care physcian of this occurrence for further direction. 3. The facility's nurses failed to store drugs under proper conditions of security. [See W381]	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services, for one of the eight clients included in the sample. (Client #1) The finding includes: Review of Client #1's records on April 15, 2008 at 10:30 PM revealed Client #1 was seen by a dentist as documented below: July 17, 2007 - the dental consultant documented that the patient needed scaling due to large deposits of plaque and calculus on all remaining teeth surfaces. November 28, 2007 - the dental consultant documented that the patient needed scaling. January 9, 2008 - the dental consultant documented that the patient needed scaling.	W 356	W356 This Standard will be met as evidenced by: A dental appointment has been completed for client #1. QMRP/medical staff will consult DDS Case Management for a list of Dental referrals, to see if there are other dentist interested in providing services to the individuals. Dental appointment will resume as ordered by the Primary Care Physician or as recommended By Dental Provider.	5.22.08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 356	Continued From page 14 Interview with the Qualified Mental Retardation Professional (QMRP) and day time nurse on April 15, 2008, at approximately 2:00 PM was conducted to ascertain if the client had the recommended scaling completed on the aforementioned consultation forms. The QMRP and day time nurse revealed that the scaling had not been completed due to the client's non-compliance and complications with the pre-authorization for the dental services. At the time of the survey, the facility failed to ensure Client #1 received the recommended dental services (scaling) in a timely manner.	W 356		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that medication nurse administered prescribed medication without error, for three of the four clients' in the sample. (Clients #3 and #4) The findings include: 1. The facility's nurse failed to administer medications in the scheduled time frame. a. On April 14, 2008 at 7:30 PM, Client #3 was observed receiving Xalthan eye drops. Interview with the medication nurse indicated that the medication time is 6:00 PM. Review of the current physician order confirmed the nurse's medication time.	W 369	W369 This Standard will be met as evidenced by: 1. QMRP/Medical LPN Staff will be in-serviced on procedures regarding the medication administration. 2. As previously mentioned, RN/DON will randomly check individual client records and monitor to ensure on-going compliance with this standard on a regular basis.	5.22.08 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	Continued From page 15 Review of the agency nursing policy and procedures indicated that the medications were to be given either one hour before or one hour after the prescribed time of administration. The nurse administered Client #2 medications onethour and 35 minutes after the prescribed time of administration. 2. On April 14, 2008 at 5:00 PM, Client #4 was observed being administered his medications. The medication nurse spilled half of theLactulose liquid on the client's lap and the floor. The medication nurse was not observed to administer any additional medication to the client.	W 369		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to store drugs under proper conditions of security. The findings include: The facility failed to ensure that each client's medications were secured during administration. 1. During the medication administration on April 14, 2008 beginning at 4:50 PM, the medication nurse was observed to leave the medication cabinet door cracked, opened and unlocked while she administered Client #5's medication in another room. At approximately 6:25 PM, the medication nurse	W 381	W381 This Standard will be met as evidenced by: As previously mentioned, RN/DON will re-in-service LPN staff on the procedures regarding medication administration. In addition, RN will complete appropriate follow-up to address individual LPN who failed to follow the outlined policy regarding medication administration and disposition of medication.	5.22.08 ongoing

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	096192	(A) BUILDING _____ (B) WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 381	Continued From page 16 was observed to leave the medication cabinet door cracked, opened and unlocked while she administered Client #3's medication in another room. Clients, staff and the surveyor ware in the area when the medication cabinet was unsecured. 2. During the medication administration on April 14, 2008 at 5:25 PM, the medication nurse was observed to prepare Client #8's medication. The client refused the medication at 5:25 PM and 6:36 PM. The medication nurse was observed to set the medication on the dining room table. Through-out the rest of the medication pass (five clients) the nurse was observed to leave the medication on the dining room table without securing the medication. At no time during or after the medication pass did the medication nurse return to secure the medication for the safety of the client and others. Clients, staff and the surveyor were in the area when the medication was unsecured.	W 381		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a sanitary environment during medication administration for one of the eight clients residing in the facility. (Client #8) The finding includes: During the medication administration observation	W 455	W455 This Standard will be met as evidenced by: 1. Reference W369	5-22-08 ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 17 on April 14, 2008 at 5:30 PM, the medication nurse was observed preparing Client #8's medications. The nurse put the medication in a souffle medication cup to crush the pills. The pills spilled on the tabletop. The nurse picked up the medication and administered the medication to the client. There was no evidence that proper infection control procedures were implemented during the medication administration.	W 455		

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID	3912 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A recertification survey was conducted from April 14, 2008 through April 17, 2008. The survey was initiated using the fundamental survey process. A random sample of four residents was selected from a population of eight males with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and one day program, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	I 000		
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that each GHMRP staff was trained in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. The finding includes: On April 15, 2008 at approximately 11:30 AM, a pan of cooked steak was observed sitting on the stove top. At 5:25 PM, dinner was servided. The meal included steak.	I 056	3502 This Statute will be met as evidenced by: QMRP/Home manager will provide additional training to staff on meal preparation. In addition, QMRP will ensure that each staff attend nutritional training at least once yearly to ensure refreshment of course as trained.	4.25.08 ongoing
I 184	3508.5(a) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart	I 184		

Nancy Brantley
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: DES

(X6) DATE: 5/8/08

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
(D)	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 184	Continued From page 1 that shows the following: (a) All major components of the administering agency or the roles of individuals when the licensee is not an agency; This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request of management staff, the GHMRP failed to provide an organizational chart depicting titles and responsibilities. The finding includes: An organizational chart was requested at the entrance conference on April 14, 2008 at 9:00 AM. This surveyor was not provided a copy of the organizational chart .	I 184	3508.5 This Stature will be met as evidenced by: (a). Organizational chart is provided inside the personnel policy and procedure. However, in order to provide easy accessibity, the home manager has transferred charts to be place inside job description book. additional training will be provided to QMRP/home manager to ensure he/she is able to provide chart when requested. (b). The current organization chart is inclusive of the program component. (c). The current organization chart provided the categories and numbers of supportive and direct care staff. (d). The current organization staff depict the lines of authority.	4.22.08 ongoing
I 185	3508.5(b) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (b) The personnel in charge of the program components; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have an organization chart the showed the personnel in charge of the program components. The finding includes: There was no organization chart that listed the personnel in charge of the program components.	I 185		
I 186	3508.5(c) ADMINISTRATIVE SUPPORT	I186		

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 186	Continued From page 2 Each GHMRP shall have an organizatidn chart that shows the following: (c) The categories and numbers of supportive and direct care staff; and... This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request of management staff, the GHMRP failed to provide an organizational chart depicting categories and numbers of supportive and direct care staff. The finding includes: An organizational chart was requested at the entrance conference on April 14, 2008 at 9:00 AM. This surveyor was not provided a copy or the organizational chart throughout the survey to determine the categories and numbers of supportive and direct care staff.	I 186		
I 187	3508.5(d) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request made of management staff, the GHMRP failed to provide an organizational chart depicting the lines of authority. The finding includes: An organizational chart was requested at the entrance conference on April 14, 2008 at 9:00 AM. This surveyor was not provided a copy or	I 187		

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 187	Continued From page 3 the organizational chart throughout the survey to determine the lines of authority.	I 187		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning of employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Review of the personnel files on April 17, 2008 failed to provide evidence that two direct care staff (Staff #4 and #5) job descriptions had been reviewed.	I 203	3509.3 This Statute will be met as evidenced by: QMRP/Home manager has reviewed staff #4 and #5 job description and is currently signed and on file. The managers will review each employee job description yearly and ensure this information is file inside a designated book for review as required.	4.21.08 ongoing
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR	I206	3509.6 This Statute will be met as evidenced by: Employees updated Health Certificates have been placed on file. QMRP/Facility Management will ensure that documentation of all employees' health status is maintained in accordance with policy and procedure/22 DCMR, Chapter 35.	4.22.08 ongoing

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 4 Chapter 35, Section 3509.6). The finding includes: The State regulatory agency conducted a review of personnel records on April 17, 2008) at which time there was no evidence that one direct care staff (Staff #4) had a current health certificate.	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The findings include: 1. The facility failed to document the implementation of programs in accordance with Individual Program Plan (IPP) for one of the four residents in the sample. [See W252] 2. The facility failed to ensure that Clients received all prescribed medications without error for two of the four residents in the facility. [See W369]	I 222	3510.3 This Statute will be met as evidenced by: 1. Reference W252 2. reference W369.	5.22.08 ongoing
I 224	3510.5(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental	I 224		

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 224	Continued From page 5 retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure effective training was provide to each staff. The finding includes: Review of the training records on April 17, 2008, revealed that the GHMRP failed to provide training in overview of mental retardation.	I 224	3510.5 (a), (b) and (c) This Stature will be met as evidenced by: The QMRP and home manager will ensure that direct care staff receive adequate training to perform duties effectively, efficiently and competently. QMRP and Home manager will receive additional training on staff training compliances. The QMRP and home manager will establish and implement an effective system to ensure that staff member were train in all areas outlined in GHMRP training compliance. In addition, QMRP/home manager will periodically review training book to ensure that all staff are trained as hired. Training director will complete a periodic audit of training book to ensure compliance with all training requirements.	5.9.08 ongoing
I 225	3510.5(b) STAFF TRAINING Each training program shall include, but not be limited to, the following: (b) Human development through the life cycle (birth to death); This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure effective training was provide to each staff. The finding includes: Review of the training records on April 17, 2008 revealed that the GHMRP failed to provide training in Human Development.	I 225		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I227		

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 227	Continued From page 6 (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in First Aid for employees. The findings include: On April 17, 2008, review of personnel records/training records revealed that only the three direct care staff (Staff #1, #2, and #3) had on file first aide and CPR cards.	I 227		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for two of the four residents included in the sample. (Residents #1 and #4) The findings include: 1 The facility failed to implement Resident #1's activities of daily living skills program as evidenced below: Review of Resident #1's Individual Support Plan (ISP) dated June 6, 2007, on April 15, 2008, at 12:30 PM revealed a goal to improve his activities of daily living skills. The objective stated "Given hand over hand assistance, [the resident]	I 422	3521.3 This Stature will be met as evidenced by: Reference W249 #1, 2, 3, 4 and 5.	5.15.08 ongoing

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 7 will brush his hair on 80% of the trials recorded for six consecutive months." Review of the QMRP's quarterly reviews reflected no program status. Review of the data sheets reflected that the program was not implemented until March 2008 (nine months later). In an interview with the QMRP on April 15, 2008, he acknowledged that the program did not start until March 2008. 2. The facility failed to implement Resident #4's Physical Therapy goal as evidenced by the following: On April 14, 2008 at 4:20 PM, the staff repositioned Resident #4 out of his wheel chair onto a mat. The staff placed the resident on his back and instructed him to stretch his legs out. The staff positioned the resident back into his wheelchair at 4:30 PM. Review of the resident's IPP on April 16, 2008 at approximately 11:50 AM, revealed that the resident had an objective to "tolerate prone position for 10 minutes." During the exit conference on April 17, 2008, it was brought to the attention of the QMRP that the resident was repositioned in the supine position instead of the prone position as indicated in the residents IPP. 3. The facility failed to encourage Resident #1 to participate in his walking program as opportunities arose. On April 14, 2008 at 8:02 AM, staff was observed propelling Resident #1 in his wheelchair into his bedroom. At 8:40 AM, staff was observed propelling the resident in his wheelchair to the van for day program. At 3:20 PM, staff was observed propelling the resident in his wheelchair	I 422	3522.11 This Statute will be met as evidenced by: 1. The expired shampoo has been discarded by the LPN. RN will provide additional training to LPN on destruction of expired medication. As previously mentioned, RN will randomly check and monitor to ensure ongoing compliance with all medication standard. 3. reference W331	5.22.08

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 8 from the van, upon arrival from the day program. At 4:00 PM, staff was again observed propelling Resident #1 in his wheelchair to his bedroom to be changed. At 6:18 PM, the resident was observed walking down the hall with staff assistance. Interview with the QMRP on April 16, 2008 at approximately 11:00 AM indicated that the Resident #1 had a walking program developed by the Physical Therapist. Review of the resident's IPP dated June 6, 2007 at 2:30 PM, revealed a program objective which stated, "Given stand by assistance, [the resident] will ambulate for 10 minutes for three days per week for 12 consecutive months". Further review of the Physical Therapy assessment dated May 2007, revealed a recommendations that the resident should use a wheelchair for long community outings, only. 4. Interview with the Day Program Coordinator on April 14, 2008 at approximately 10:30 AM indicated that Resident #1 likes staff to rub his head. However the staff have been instructed to shake the resident's hand. On April 14, 2008 at 3:55 PM, Resident #1 was observed rubbing his head on a direct care staff's chest and arm. Staff #1 shook his hand and then prompted the client to rub his own head. Interview with the Staff #1 indicated that the resident likes to have his head rubbed. However there is a protocol in place for staff to implement when the resident request a "head rub". At 6:52 PM, Staff #2 was observed rubbing Resident #1's head for three minutes. The resident smiled broadly. Review of the Resident #1's protocol developed by the Social Worker revealed the following steps:	I422		

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G132	(A) BUILDING _____ (B) WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 9 - When staff greet Resident #1, the staff should give him a firm hand shake; - When Resident #1 attempts to get staff to rub his head, staff should refuse and continue to shake his hand and say, "[the resident] it's nice to shake hands"; and - After shaking hands, without rubbing [the resident's] head, staff should again say, "[the resident] it's nice to shake hands. There was no evidence that the facility implemented Resident #1's protocol as written.	I422		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to promptly destroy prescribed medication that was discontinued by the primary care physician for one of the four residents in the facility. (Resident #8) The findings include: 1. During the environmental inspection on April 17, 2008 at 2:10 PM, a bottle of Loprox 1% shampoo was expired (manufacturer label) and had no label on it. Review of Resident #8's current physician order revealed no evidence of an order. However interview with the Licensed Practical Nurse indicated that the shampoo had been discontinued.	I 484	This Statute will be met as evidenced by: Reference response to Federal Deficiency report W 331.	5.22.08

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	A. BUILDING _____ B. WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 484	Continued From page 10 2. The facility failed to properly destroyed medications. During the medication administration observation on April 14, 2008 at 5:30 PM, the medication nurse was observed preparing Client #8's medications. The nurse put the medication in a souffle medication cup to crush the pills. While crushing the medication, three fours of one pill (Dilantin 50 mg) feel to the floor. The medication nurse continued to crush the remaining pills. At 6:35 PM, the medication nurse attempted to administer the client's medications. At that time the client refused. At 7:35 PM, the client was observed received his medication. Interview with the medication nurse indicated that the medication time is 6:00 PM. Review of the current physician order confirmed the nurse's medication time. Review of the agency nursing policy and procedures indicated that the medications were to be given either one hour before or one hour after the prescribed time of administration. The nurse administered Client #8's medications one hour and 35 minutes after the prescribed time of administration. NOTE: At 7:35 PM, the medication nurse was informed that the Dilantin pill fell to the floor, at that time she administered another Dilantin pill. The medication nurse was observed throwing the Dilantin pill in the trash can. It should be noted that the pill was administered after the scheduled time.	I 484	3523.1 This Stature will be met as evidenced by: Reference W124	5/1/08
I 600	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure	I 500		

PRINTED: 04/28/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G192	(A) BUILDING _____ (B) WING _____	04/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 11 that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with federal regulations 42 CFR 483.420. The findings include: 1. The facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for two of the four clients in the sample. [See Federal Deficiency Report citation W124] 2. The facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for two of the four clients in the sample. [See Federal Deficiency Report citation W268]	I500		